treatment of infantile hypertrophic pyloric stenosis. *Arch Dis Child* 1988; **63**: 1060–4.
2 Leahy PF, Farrell R, O'Donnell B. 300 Infants with hypertrophic pyloric stenosis: presentation and outcome. *Ir Med J* 1986; **79**: 114–16.
3 Carle G, Davidson AR. Infantile pyloric stenosis in the North East of Scotland. *J R Coll Surg Edinb* 1985; **30**: 30–3.
4 Bristol JB, Bolton RA. The results of Ramstedt's operation in a District General Hospital. *Br J Surg* 1981; **68**: 590–2.
5 Spitz L. Pyloromyotomy. In: Spitz L, Homewood Nixon H eds. *Rob and Smith's Operative Surgery. Paediatric Surgery.* 4th Edition. London: Butterworths, 1988: 267–72.
6 Scharli AF, Leditschke JF. Gastric motility after pyloromyotomy in infants. A reappraisal of postoperative feeding. *Surgery* 1968; **64**: 1133–7.
7 Shucksmith HS. Congenital pyloric stenosis. *Univ Leeds Mag* 1950; **20**: 1–2.

The use of Coca-Cola in the management of bolus obstruction in benign oesophageal stricture

The use of Coca-Cola or other fizzy drinks as reported by Karanjia and Rees (*Annals*, March 1993, vol 75, p94) to clear bolus food obstruction in the presence of an oesophageal stricture or after insertion of a Procter–Livingstone tube has been widely known in Transkei where oesophageal carcinoma is common. It has been alluded to in earlier surgical literature.

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Reference

1 Cotton MH, Sammon AM. Carcinoma of the oesophagus in Transkei: treatment by intubation. *Thorax* 1989; **44**: 46.

I read with great interest the article by Karanjia and Rees (*Annals*, March 1993, vol 75, p94). This article deserves several comments.

First, I do not agree with the authors' comment on pushing the food bolus or foreign body through the oesophageal stricture, in the event of unsuccessful retrieval. This may cause oesophageal perforation and should be avoided, since the instrumental perforation of the oesophagus is a serious and potentially fatal complication of oesophagoscopic procedures, irrespective of the skill of the operator and the type of instrument used *(1)*.

Second, in their study, they successfully cleared the food bolus obstruction by the use of Coca-Cola, an aerated drink. The use of such a method is not a new concept. Mohammed and Hegedüs in 1986 *(2)* effectively dislodged impacted oesophageal foreign bodies with carbonated soda water in 16 out of 20 patients with a normal oesophagus or with oesophageal motility disorders and organic strictures. They suggested the use of carbonated beverages as the first line of treatment of acute episodes of oesophageal obstruction due to foreign body and should also be integrated in the management of patients with oesophageal motor and stenosing organic disease. Rice *et al. (3)* reported a 100% success rate in relieving acute oesophageal food impaction by the use of gas-forming carbonated beverages, 'cocktails' of tartaric acid and sodium bicarbonate. Campbell and Sykes *(4)* also described the use of 'Carbex' effervescent granules (sodium bicarbonate, activated dimethicone and citric acid) as a non-endoscopic relief of oesophageal obstruction due to food bolus. After having continued success without any complication, Campbell and Sykes *(5)* recommended the use of 'Carbex' granules normally used in double contrast barium meal examination as a convenient way to administer the fizzy drinks. After reading their article, on many occasions I have cleared acute food bolus obstruction in our casualty department with 'Carbex' granules without any ill effects where fizzy drinks have failed to solve the problem. Ignotus and Grundy *(6)* disimpacted a large food bolus obstruction of the lower oesophagus in a patient by intravenous hyoscine butylbromide followed by oral intake of 'Baritop' tablets, an agent used in double contrast studies. Other methods, such as nifedipine a calcium channel blocker have been used in the treatment of distal oesophageal food impaction *(7)*. However, this drug should be used with caution.

Finally, in addition to these various methods and armamentarium, Saeed *et al. (8)* described an efficient, safe and new method for managing food impaction of the oesophagus, where the endoscope itself becomes a direct-vision suction device. In spite of the availability of several methods of treatment, it is the endoscopist who should endeavour a simple, safe, efficient and cost-effective technique for the relief of food bolus obstruction in the presence or absence of organic strictures and motility disorders of the oesophagus.

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References

1 Moghissi K. Instrumental perforations of the oesophagus. *Br J Hosp Med* 1988; **39**: 231–6.
2 Mohammed SH, Hegedüs V. Dislodgement of impacted oesophageal foreign bodies with carbonated beverages. *Clin Radiol* 1986; **37**: 589–92.
3 Rice BT, Spiegel PK, Dombrowski PJ. Acute oesophageal food impaction treated by gas-forming agents. *Radiology* 1983; **146**: 299–301.
4 Campbell N, Sykes P. Non-endoscopic relief of oesophageal obstruction. *Lancet* 1986; **2**: 1405.
5 Campbell N, Sykes P. Disimpaction of swallowed bolus. *Br Med J* 1989; **299**: 53.
6 Ignotus PI, Grundy A. Disimpaction of swallowed bolus. *Br Med J* 1989; **298**: 1359.
7 Bell AF, Eibling DE. Nifedipine in the treatment of distal oesophageal food impaction (letter). *Arch Otolaryngol Head Neck Surg* 1988; **114**: 682–3.
8 Saeed ZA, Michaletz PA, Feiner SD, Woods KL, Graham DY. A new endoscopic method for managing food impaction in the oesophagus. *Endoscopy* 1990; **22**: 226–8.

Surgical audit without autopsy: tales of the unexpected

I read with interest the article by Messrs Mosquera and Goldman (*Annals*, March 1993, vol 75, p115). However, I would question the logic of their call for more autopsies and more laparotomies ('look and see').

In a retrospective study, the clinical cause of death gleaned from death certificates and case sheets will regrettably not be a complete reflection of the diagnostic possibilities considered by the surgical team. In nearly all cases tabulated, only one pre-autopsy diagnosis is specified, whereas the fact than an autopsy was requested implies some uncertainty and indicates that other diagnoses will have been contemplated.

Extending the scope of post-mortem examination to cases where there is less clinical uncertainty would probably produce